Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001148	A. BUILDING: _____ B. WING _____	C 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	**17650 GENERATIONS DR SOUTH BEND, IN 46635**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00131908. Complaint #IN00131908 -Substantiated. No deficiencies related to the allegations are cited. Survey Date: July 3, 2013 Facility ID Number: 001148 Provider: N/A AIM Number: N/A Survey Team: Julie Wagoner, RN TL Deb Kammeyer, RN Census bed type: Residential: 68 Census Payor type: Medicaid: 53 Other: 15 Total: 68 Sample: 3 Woodridge Assisted Living was found to be in compliance with 42 CRF Part 483, Subpart B in regard to the Investigation of Complaint #IN00131908. Quality Reivew 07/05/13 by Lisa McColly	R 000		